City of Long Beach
DEPARTMENT OF HUMAN RESOURCES
REASONABLE ACCOMMODATION ASSESSMENT

Please answer each question, and attach <u>all</u> pertinent information explaining your response.

COMPLETED BY DEPARTMENT

Date_____ Job Analysis Attached ☐ Employee ☐ Applicant ☐

Name:_____ Classification: _____

Department/Bureau/Division: _____

Name/Title/Phone # of completing form:_____

1. What Action initiated the need for a reasonable accommodation assessment?

   ☐ request by employee/applicant due to physical/mental limitations ☐ results of medical exam ☐ Other

2. Can the employee/applicant perform the essential functions without accommodation? ☐ Yes ☐ No
3. What essential functions can the job applicant/employee not perform without an accommodation? List specific duties (example: filing, typing, loading, etc.). Attach sheet if additional space is required.

   _____ _____ _____

   _____ _____ _____

4. Have you met with the employee/applicant to ask him/her how to effectively accommodate his/her limitations? Attach sheet if additional space is required.

Date	Accommodation(s) Requested
_____	_____
_____	_____

5. Have you contacted the Job Accommodation Network (JAN) (800) 232-9675, for suggestions? (maintain names & dates).

   Comments:

6. Have other applicants with similar limitations been accommodated in the same type of job in question? Please explain.

7. Pease refer to the essential functions listed in #3 above. List and review each essential function separately in the boxes below. Use additional sheets to explain your answer.

   Essential Function:_____

   Have the following items been considered? (please circle). Circle "N/A" if not applicable

   Essential Function:_____

		Is it possible to accommodate		
a.	Worksite modification to allow accessibility	Yes	No	N/A
b.	Job restructuring	Yes	No	N/A
c.	Modified work schedule	Yes	No	N/A
d.	Flexible leave policy	Yes	No	N/A
e.	Reassignment to vacant position in the same classification within department	Yes	No	N/A
f.	Modification of existing equipment or devices	Yes	No	N/A
g.	Acquisition of assistive equipment or devices	Yes	No	N/A
h.	Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
I.	Adjustment or modification of training	Yes	No	N/A
j.	Assistive equipment or devices owed by employee/applicant	Yes	No	N/A
k.	Other accommodation(s) considered:_____			

   Proposed Accommodation:_____

Reasonable Accommodation Assessment (continued)

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Essential Function:_____

Have the following items been considered? (please circle). Circle "N/A" if not applicable

Essential Function:_____	Is it possible to accommodate		
a. Worksite modification to allow accessibility	Yes	No	N/A
b. Job restructuring	Yes	No	N/A
c. Modified work schedule	Yes	No	N/A
d. Flexible leave policy	Yes	No	N/A
e. Reassignment to vacant position in the same classification within department	Yes	No	N/A
f. Modification of existing equipment or devices	Yes	No	N/A
g. Acquisition of assistive equipment or devices	Yes	No	N/A
h. Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
I. Adjustment or modification of training	Yes	No	N/A
j. Assistive equipment or devices owed by employee/applicant	Yes	No	N/A
k. Other accommodation(s) considered:_____			

Proposed Accommodation:_____

Essential Function:_____

Have the following items been considered? (please circle). Circle "N/A" if not applicable

Essential Function:_____	Is it possible to accommodate		
a. Worksite modification to allow accessibility	Yes	No	N/A
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e. Reassignment to vacant position in the same classification within department	Yes	No	N/A
f. Modification of existing equipment or devices	Yes	No	N/A
g. Acquisition of assistive equipment or devices	Yes	No	N/A
h. Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
I. Adjustment or modification of training	Yes	No	N/A
j. Assistive equipment or devices owed by employee/applicant	Yes	No	N/A
k. Other accommodation(s) considered:_____			

Proposed Accommodation:_____

I certify that the above is a true and correct assessment of providing reasonable accommodation for applicant/ employee's job-related restrictions. (sign & date)

_____ _____

Supervisor/Manager completing assessment Date **Department Head or Designee Date**

Department's meeting with employee/applicant to discuss results of assessment (maintain full documentation in file)"

Date_____

Brief summary of meeting

COMPLETED BY HUMAN RESORUCES DEPARTMENT

Concur with assessment _____

Director of Human Resources/Designee